

EVALUATION FOR PERMANENT IMPAIRMENT

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

Employer FEIN _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employee's Name _____			Employer's Name _____ () _____			Telephone Number _____		
Address _____			Employer's Address _____			City _____ State _____ Zip _____		
City _____ State _____ Zip _____			Insurance Carrier _____					
() _____			() _____					
Home Telephone _____			Work Telephone _____			Carrier's Address _____ City _____ State _____ Zip _____		
Social Security Number _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F			Date of Birth _____ / _____ / _____			() _____ () _____		
Date of Injury: _____			Carrier's Telephone Number _____			Fax Number _____		

EMPLOYEE'S WORK-RELATED INJURY WILL RESULT IN:**MEMBER****% OF IMPAIRMENT**

(IF AMPUTATION, DESCRIBE ON REVERSE.)

1) Thumb	_____	_____
2) Index Finger	_____	Physician Signature
3) Middle Finger	_____	
4) Ring Finger	_____	
5) Little Finger	_____	
6) Great Toe	_____	Printed Name
7) Toes (other than great toe)	_____	
8) Hand	_____	Fed. Tax ID Number
9) Arm	_____	
10) Foot	_____	Date
11) Leg	_____	
12) Back	_____	Address

In regard to this rated body part:

- 1) Is employee at maximum medical improvement? _____
- 2) Was employee released with restrictions? _____

TEETH: Age of employee: _____

List all crowns by number : _____

List all extractions by number : _____

Has dental work been completed? ☐ Yes ☐ No

VISION: List vision reading without the use of a corrective lens.

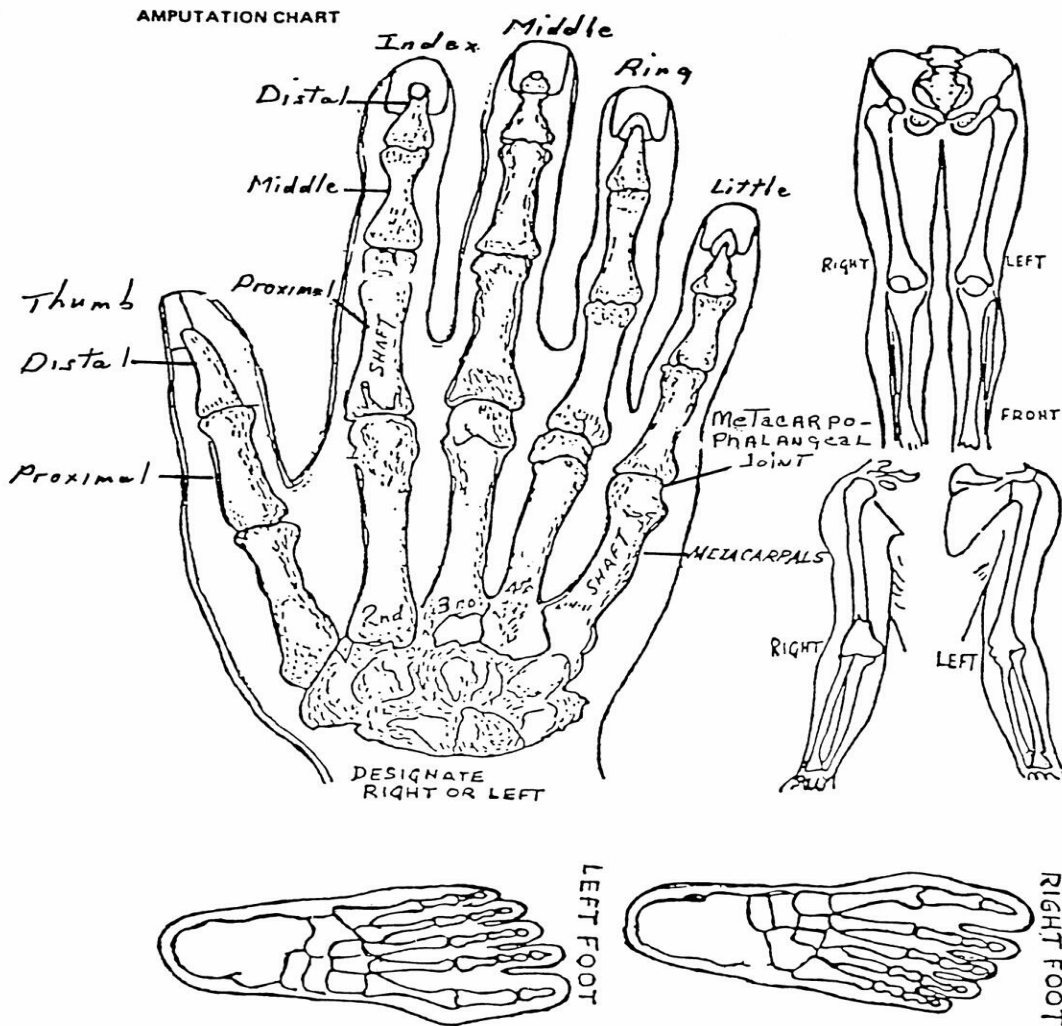
Distance: _____ Near: _____

HEARING: Scale used: _____ Percentage of loss: Right ear _____

PLEASE ATTACH AUDIOGRAMS AND CALCULATIONS OF HEARING LOSS Left ear _____

OTHER: Permanent injury to or impairment of any other organ or part of body (identify) : _____

Disfigurement: ☐ Yes ☐ No Location: ☐ face ☐ head ☐ body



Comments: _____

Rule 405
Computation of Compensation for Amputations

- (1) Amputation of any portion of the bone of a distal phalange of a finger or toe at or distal to the visible base of the nail will be considered as equivalent to the loss of one-fourth ($1/4$) of such finger or toe.
- (2) Amputation of any portion of the bone of the distal phalange of a finger or toe proximal to the visible base of the nail will be considered as equivalent to the loss of one-half ($1/2$) of such finger or toe.
- (3) Amputation through the forearm at a point so distal to the elbow as to permit satisfactory use of a prosthetic appliance with retention of full natural elbow function shall be considered amputation of the hand. Otherwise, it shall be considered amputation of the arm.
- (4) Amputation through the lower leg at a point so distal to the knee as to permit satisfactory use of a prosthetic appliance with retention of full natural knee function shall be considered amputation of the foot. Otherwise, it shall be considered amputation of the leg.

A copy of this form must be provided to the employee or the employee's attorney of record if any. The original should be mailed to the Industrial Commission at the address below.